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VISIT...

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قال تعالى:

أَمْ حَسِبْتُمْ أَنْ تُدْخَلُوا الْجَنَّةَ

وَلَمَّا يَعْلَمِ الَّذِينَ جَاهَدُوا

مِنْكُمْ وَيَعْلَمِ الصَّابِرِينَ

أَلْ عَمْرَان ١٤١

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Rheumatology [Page 2]

- Often affects any joint usually **big toe**, but may be poly-articular & affects any joint.

Diagnosis:

- History:** Ask about
 - Spontaneous onset of **severe joint pain in one joint** exacerbated by movement.
- Examination:** Look for
 - Inflammation of joint (red, hot & swollen)
 - Gouty nodules** around ears, bursae or tendons which suggest chronic gout

Investigation:

- Serum uric acid:** usually raised in gout but is non-specific. Creatinine: in chronic gout you should excluded kidney damage
- Lipids:** hyperlipidaemia usually coexist & gout.
- Uric acid:** of gout is obvious after history & examination
- If not aspirate the joint → uric acid crystals in the synovial fluid are diagnostic.

Management:

Advice

- Avoid prolonged fasts
- Avoid alcohol
- Avoid overweight (lose wt.)
- Avoid diuretics especially thiazide diuretics
- Avoid purine rich food (e.g. offal, oily fish, pates, meat especially beef, lamb)
- Avoid low dose aspirin (↑serum urate)
- منع تناول اللحوم والكي والكبدة والحمية والكحول والبقوليات والسبانخ والكرنب وعيش الغراب.

Remember:
Thiazides cause gout

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Rheumatology [Page 1]

1. Joint pain S&R

Diagnosis:

- History:** ask about
 - The duration of symptoms:** a short-term illness requires a diagnosis. In long term problems first find out what the patient wants: symptoms relief or reassurance.
 - Associated features** such as viral illness, depression or fatigue.
 - Generalized or localized symptoms.
 - Diurnal symptoms.
 - Joint stiffness.
- Examination:** Look at
 - The affected area for inflammation, deformity or ↓ed movement.
 - Nearby structure such as the neck, shoulder pain.
 - Whether it is joint problem, peri-articular or muscular.
 - Tender spots & as in tennis elbow & fibrosis.
 - Other areas as suggested by the history.

Causes of joint pain:

- Unaccustomed use
- Repeated overuse
- Viral illness
- Osteoarthritis
- Non articular rheumatic pain e.g tennis elbow
- Gout
- Polymyalgia rheumatica
- Rheumatoid arthritis
- Other connective active tissue disorders e.g SLE, systemic sclerosis.
- Malignancy or & myeloma
- Trauma
- Post-infective: rheumatic fever

Investigations:

ESR, CRP, CBC, RF, serum uric acid.

2. Gout القرص D&T

- Presents most commonly in **middle aged males**.

Acute gout

- Severe joint **redness, pain & swelling** in ankle or knee

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Rheumatology [Page 3]

Prescribing:

Acute

- Strong NSAID:** Indomethacin 50mg. 1x3
R/INDOCID CAP. (50) 1x3
- Colchicine** 0.5-1mg. t.d.s or 0.5mg. / xdh po until pain goes or diarrhea & vomiting occur or 6mg given
o R/COLCHICINE 1x3 OR 1x4 OR
R/URSOLVINE EFF. 1x3
o NSAID & colchicine are problematic in renal impairment
- For recurrent attacks prescribe: **Allopurinol** 100mg. /day (max. 300mg./8hrs.)
o R/ZYLORIC 100,300 1x3
o Don't start allopurinol until attack ↓ so, wait until 3 weeks after an acute attack
- Refer severe or resistant cases to rheumatologist.

Remember:
Zyloric exacerbates acute attack of gout and treats chronic gout.

3. Osteoarthritis D&T

- The most common joint disease seen in GP
- Male to female = 3:1
- Usually > 50 yrs.

Symptoms and Signs:

- Localized disease (usually hip or knee or ankle)

- Pain on movement
- Creptus, **worse at the end of the day**.
- Back pain at rest
- Joint gelling = stiffness after rest up to 30 minutes
- Early morning stiffness
- Joint instability
- Creptus may be heard by lying a hand on the joint while moving
- Creptus may be heard by lying a hand on the joint while moving

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Management:

1. ↓ Weight **مهم جدا**
2. Quadriceps exercise to ↑ Ms strength & ↑ knee stability **أربك عجل**
3. Give paracetamol for pain relief
4. NSAIDs e.g. Ibuprofen SR 800mg. 2 tab. at night
R/BRUFEN RETARD 2 TAB. AT NIGHT
Or give **R/BREXIN 1X3** **بد الأكي**
Or give **R/BREXIN 1X3** **بد الأكي**
5. Beware of the risk of gastric irritation from NSAIDS
6. Prescribe PPI e.g. omeprazole 10mg. 1x1
R/OMEZ 10MG. 1x1 or R/RABICID 20MG 1X1
7. Give topical NSAID.
R/OLFEN GEL 1X3
8. Consider glucosamine 1500mg/d
R/GLUCOSAMINE CAP. 1x3
9. Physiotherapy is useful for maintaining joint mobility.
10. If poor response consider referral for
 - Intra-articular steroid injection
 - Walking aids
 - Joint replacement.



Osteoarthritis

Symmetrical, small and large joints

4. Shoulder pain **SgR**

Causes

1. Can be a symptom of problems in the neck such as cervical spondylosis
2. Usually caused by adhesive capsulitis (frozen shoulder)
3. Rotator cuff syndrome (e.g. supraspinatus tendonitis)
4. Cardiac ischemia (MI)
5. Diaphragmatic irritation as (gall stones, subphrenic abscess)

Diagnosis:

- History: Ask about
 1. Any hx of trauma, such as a fall on the arm
 2. Previous episodes of similar problems.
 3. Neck pain

4. Occupation and handedness: repetitive use of the arm may account for shoulder problems.

Examination: Look for

1. Bruising which may suggest a fractured neck of the humerus, especially in an elderly person following a fall.
2. Limitation of movement of the glenohumeral joint in frozen shoulder
3. The painful arc: pain increases as the shoulder is abducted to about 90° but reduced again as the arm is raised further above the head. This is a feature of supraspinatus tendonitis

Ask the patient to put their arms behind their head, and note the angle at which any restriction & pain occurs.

Tip: Neck problems often present with shoulder pain

Management:

1. Physiotherapy can be useful for some painful arc syndromes, but is of little value in the treatment of frozen shoulder.
2. NSAIDs (if not CI) are useful in reducing pain and inflammation.
R/OLFEN 50 TAB. 1X3
R/OLFEN GEL 1X3
3. The injection of long acting steroids into the subacromial space is useful in the treatment of supraspinatus tendonitis e.g. **methvl prednisolone 40mg with 2% plain lidocaine 2ml**. Or **R/KENACORT VIAL**

* Warn the patient the pain will get worse over the ensuing 24 hrs if improvement is partial, a second injection is useful.

N.B: Beware in the fractured neck of the humerus. This is usually more painful initially. Bruising develops over the 1st 48 hrs. Some movement of the glenohumeral joint is often possible.

Frozen shoulder (adhesive capsulitis)

- Affects patients 40-60 ys
- Painful, stiff shoulder with global limitation of movement especially external rotation (difficulty in brushing hair or putting on shirts or bra).
- Pain is often worse at night
- Cause is unknown but increase in diabetics and those with intra-thoracic pathology (MI, lung disease) or neck disease.

References & Sources:
1. GP p246, 247
2. Oxford handbook of general practice p552

5. Rheumatoid arthritis (RA): (specialist case) **DgR**

- Immunological chronic inflammatory disease.
- Characterized by **deforming peripheral polyarthritis**.
- Peak onset 4th - 5th decades.
- Female: Male > 2:1.

Diagnosis:

- History: ask about

1. Joint pain
 - Symmetrical.
 - Morning stiffness especially in the **small joints of the hands and feet.**
 - The distal inter-phalangeal joints are usually spared.
 - Swelling of joints often occurs
2. Other symptoms
 - General malaise.
 - Weight loss.
 - Carpal tunnel syndrome.
 - Tenosynovitis.

- Examination (signs): Look for **Joints**: red, hot, tender, swollen and painful to move, especially MCP and PIP and metatarsal joints. (early stages)



Rheumatoid arthritis

Symmetrical, small and large joints, upper and lower limbs

Examination (signs): Look for

1. **Joints**: red, hot, tender, swollen and painful to move, especially MCP and PIP and metatarsal joints. (early stages)
2. **Later joint damage and deformity**:
 - Ulnar deviation of the fingers and dorsal wrist subluxation and swan neck deformities of fingers or Z-deformity of thumbs. (Swan = بجمعة)
 - Hand extensor tendons may rupture.
 - Atlanto-axial subluxation may threaten the spinal cord.
3. **Carpal tunnel syndrome**
4. **Extra-articular nodules** (extensor surface of the forearm, elbows, lungs)



Boutonniere deformity



Swan neck deformity

Investigations:

- All suspected cases of RA should have ESR or CRP and if raised **Do the following**:
- CBC
 - **Rheumatoid factor**: positive in 80% but 5% are false positive
 - **ANA**: Antinuclear antibody: should be negative to exclude SLE
 - **Serum uric acid**: should be normal to exclude gout
 - X-ray of the hand & feet: characteristic appearance of RA appear after 6 months of disease (loss of joint space, erosions, joint destruction)

Management:

- Refer early to rheumatologist as early use of disease modifying drugs (DMARDs) can improve symptoms and long term outcomes.
- 1. Resting acutely inflamed joints reduces pain. Passive movements help to prevent deformity.
- 2. Give simple analgesia as Paracetamol **R/PANADOL 900 2X4**

NSAIDs

- You don't know which NSAID will affect so alternate until you know.
- Give **R/BRUFEN 400 IX3** OR **R/VOLTAREN 50 IX3**
- Give PPI to protect the stomach
R/PEPTAZOLE 30 IX1
- Encourage regular exercise, physiotherapy and occupational therapy e.g. aids, splints
- IM steroids and intra-articular steroids
- Surgery (e.g. ulnar stylectomy, joint replacement)
- Some patients find **fish oils** and **evening primrose oil** helpful
- Advise patient against being overweight.

Beware of potential complications e.g.

- Septic arthritis
- Neutropenia
- Drug side effects
- Dry eyes
- Nodules
- Leg ulcers
- Pulmonary fibrosis
- Peripheral neuropathy
- Atlanto-axial subluxation and quadriplegia in cervical spine involvement.

References:

1. GP: p244, 245, 246
2. OHCMA: p532, 533
3. Oxford handbook of general practice: p572, 573, 574

6. Low back pain SGT

- Very common and self-limiting.
- Acute onset of lumbar back pain usually follows lifting and often radiates to the buttocks or legs.

Diagnosis:

History:

1. **Onset:** sudden? (Related to trauma) or gradual?
2. **Motor or sensory symptoms?** Muscle weakness in the LL or paraesthesia?
3. Is the bladder or bowel affected? → Spinal disc? spinal injury?
4. Is there **sciatica**? True sciatica radiates into the buttocks, back of the thigh and below the knee into the calf and ankle. This is caused by sciatic nerve irritation and is usually due to a **prolapsed disc**.
5. Exclude pain referred to the back (**GI or GU pain**).

Examination:

1. Assess flexion, extension, lateral flexion and rotation of the back whilst standing.
2. Ask to lie down: This gives a good indication of how severe symptoms are.
3. In LLs, **look for muscle wasting** and check power, sensory loss and reflexes (knee jerk and ankle jerk)
4. **Assess straight leg raise (SLR):** sciatica is present if SLR elicits back/buttock pain compared to the other side.

"Red Flag" signs

- < 20 ys or > 55 ys.
- Non-mechanical pain.
- Nocturnal pain.
- Past history of carcinoma.
- Thoracic pain.
- Morning stiffness.
- Taking steroids.
- Weight loss, fever, night sweats.
- Constant or progressive pain.
- Acute onset in elderly people.
- ↑ pain on being supine

Causes of back pain "Age suggests the most likely cause"

15-30 ys

Prolapsed disc, postural, mechanical, trauma, fracture, ankylosing spondylitis, pregnancy.

30-50 ys

Postural, degenerative joint disease, prolapsed disc, Paget's, malignancy (myeloma??), spondyloarthropathies.

> 50 ys

Postural, degenerative, osteoporotic collapse, Paget's, malignancy, spinal stenosis.

Prevention of back pain:

- Regular exercise
- Optimal weight
- Advise posture
- Correct lifting technique

Management of acute back pain

1. Advice to avoid bed rest and try to maintain normal activities (↓ chance of chronic pain).
2. X-ray is usually negative but important to exclude:
 - Ankylosing spondylitis and SI joints in < 25ys
 - Vertebral collapse / malignancy in the elderly
3. Give analgesia

R/OLFEN AMP

R/VOLTAREN 50MG TAB. IX3

Muscle relaxant + Paracetamol

R/MYOLGEN CAP IX3

R/SIRODALUD 4MG (CENTRAL MUSCLE RELAXANT) IX1 قرص مساملا

Refer patients not returning to normal activity within 6 weeks

6. Chronic back pain: Refer

References:

1. GP: p251, 252

7. Osteoporosis (some information) هشاشة العظام SGT

- Osteoporosis is the **most common in post menopausal women**.
- It is characterized by a decreased bone density due to demineralization.

Diagnosis:

- The condition itself is **asymptomatic**.

Patients at increased risk:

- Post menopause
- Family hx of osteoporosis
- Smoking
- Lack of exercise
- Thin build
- Steroids

Examination: patients present in the following ways

- Fractured hip or wrist
- Back pain which appears on x-ray to be due to vertebral fracture.

Management:

1. Maintain body weight so **BMI < 19 kg/m²**
2. Give **Ca²⁺** supplements to post menopausal women and Vit D.
3. **Regular exercise:** weight bearing activity > 30 min/day decrease fracture rate.
4. Stop smoking.
5. Stop or ↓ alcohol consumption.

١. تناول وجبات تحتوي على الكالسيوم وفيتامين د مثل اللبن ومنتجاته

Treatment: (By specialist)

1. **R/CALCIUM SANDOZ TAB** قرص على ١/٢ كوب ماء مرتين يوميا
- R/MIACALCIC AMP** أمبول تحت الجلد أو بالعضل يوميا أو يوم بعد يوم
2. **Anabolics:**
- R/DECA-DURABOLIN AMP** أمبول عضل كل ١٥-١٠ يوم
3. **Bisphosphates:** **R/POSAMAX ١0 IX1** (alendronic acid) by specialist only

8. Polymyalgia rheumatica (PMR) and Giant cell arteritis DGR

- PMR is mainly affecting women > 55 ys
- PMR coexists with GCA in about 30% of cases

1. PMR

- Gradual onset, symmetrical pain, tenderness and morning stiffness in the shoulders and proximal limb muscles

- **Systemic symptoms:** fatigue, fever, weight loss, anorexia and depression

2. Giant cell arteritis (temporal or ophthalmic arteritis)

- **Symptoms:** headache, unilateral temporal artery tenderness, scalp tenderness.
- Ask about visual loss or diplopia
- **Examination:**
 - **PMR:**
 - Look for mild tenderness on palpation of the shoulder muscle.
 - Patients with PMR have difficulty in raising their hands above their heads
 - **GCA:** Look for a tender temporal artery on palpation

N.B:

- Giant cell arteritis is an **ophthalmological emergency** due to risk of sudden blindness
- If you suspected GCA refer urgently to ophthalmologist.

Investigations:

1. ESR

- A result **> 50** is strongly supportive of the diagnosis of PMR.
- If a border line ESR is obtained repeat after 48 hrs.
- Do not await the ESR result if there is a strong suspicion of GCA. **Start 40-60mg prednisolone/day immediately.**
- 2. If ESR is very high exclude myeloma with serum electrophoresis (para-protein band) and urine electrophoresis (Bence-jones protein).

3. TFTs to exclude hypothyroidism

Management:

1. **For PMR:** Prednisolone 10-20 mg/day, expect dramatic response within 4 days **R/SOLUPRED (5, 20MG)**
- ↓ dose slowly by 1mg/month (according to symptoms and ESR)
- Most need steroids for ≥ 2 ys, So prevent osteoporosis.

- **Examination:**
 - **Wasting of the small muscle of the hand** indicates severe nerve compression (Refer for decompression)
 - The symptoms are exacerbated by tapping on the median nerve at the wrist.

Management:

1. Rest the affected hand
2. NSAIDs
3. Injection of **methylprednisolone 40mg** with local anaesthesia (by specialist)
4. Refer to orthopedic for carpal tunnel release

References: see GP, p. 249, 250

11. Ganglion S&R

- It is a **firm, cystic swelling** usually around the dorsum of the wrist or hand
- Can also be found around the ankle
- The problem is usually cosmetic.

Management:

1. Inform the patient that 50% of all ganglions disappear spontaneously in time.
2. **Aspirate** the lump under local anaesthesia using 21G needle
3. Or **pierce the ganglion several times** with a fine hypodermic needle and **press on it gently** for several seconds while the contents disperse
4. In both cases recurrence is possible, so warn the patient of this
4. Refer to orthopedic for excision if the above failed

Source: GP, p.250

12. Paronychia D&T

- It is a **suppurative collection** around a fingernail
- The pus can easily be seen adjacent to a nail as a white tense, tender swelling.

9. Tenosynovitis S&R

- Tenosynovitis is inflammation of the tendons of the dorsum of the hand or foot
- It is commonly presents in GP following **repetitive overuse** and occasionally can occur spontaneously

Diagnosis:

History:

- Ask about pain and tenderness over the tendons, usually of the hand, where they cross the wrist within a synovial sheath.
- The pain is worsened by movement of the tendon within the sheath

Examination: Look for

- Swelling
- Tenderness and exacerbation of the pain on palpating the affected tendon

Management:

1. **Rest for 2-3 weeks with immobilization** is often all that is needed.
2. A temporary change of use of the hand may help.
3. Short course of NSAIDs **R/VOLTAREN 50 TAB. IX3**
4. **An injection of hydrocortisone** with local anaesthesia (by rheumatologist or orthopedic surgeon) **R/KENACORT VIAL**
5. Refer for surgical decompression if the above failed

10. Carpal tunnel syndrome D&R

- It is the most common cause of parasthesia in GP.

Diagnosis:

History:

- Ask about pain and tingling in the median nerve distribution of the hand (**radial 3 1/2 digits**)
- It is usually worse in the morning and can be relieved temporarily by shaking the hand vigorously

Management:

1. **Spray the paronychia with ethyl chloride** for 5-10 seconds or until a frost develops
2. **Incise** into the paronychia using a No 11 scalped blade and let the pus out
3. **Gently squeeze** below the nail bed to "milk" the pus from the finger then dress it.
4. If there is surrounding cellulitis, give **R/FLUMOX 124 OR UNASYN 1.5 6 IX2X5 DAYS THEN R/UNASYN 575 IX3X4 DAYS**
5. Use local Ab **R/FUCIDIN OINT. IX2**

Source: GP 250, 251

13. Sprained ankle D&T جليق عليها ثغروق في الأربعة

- This is a common soft tissue injury in GP.
- Usually **due to inversion of the ankle** damaging the lateral talo-fibular ligament.
- Nearly all soft tissue sprains settle with rest followed in severe cases by physiotherapy

You should exclude fractured ankle early

Diagnosis:

History: ask about:

- Falls from a height / down a hole
- Previous ankle
- Running / jumping injury

Examination: Look for

- Tenderness below the lateral malleolus

Tip:

Examine the base of the 5th metatarsal for fractures which is more common of the injury is due to a fall e.g. off the edge of a kerb.

Management:

1. **RICE: Rest, Ice, Compression, Elevation**

2. Mobilize gently after 24 hrs
3. Refer more severe sprains e.g. sports injuries for physiotherapy early
4. Complete resolution of swelling may take several months

Tip

Pain, swelling and bruising get worse over the first 24 hrs in the sprained ankle. Use ice for 10-15 minutes at a time

5. Give
R/REPARIL 40 TAB 1x3 OR R/AMBEZIM 1x3 (CHEMOTRYPSIN)
مع الرباط العائظ
R/REPARIL 66L 1x3
R/XELO 8, 16 TAB 1x3
6. Refer if not improving
Source: GP, p254, 255

14. Painful Heel (Plantar Fasciitis) 5gR

- Plantar fasciitis cause chronic pain under the heel especially when taking the first steps in the morning with no history of trauma

- There is usually a tender point just in front of the bony part of the heel
- The condition usually resolves spontaneously often several months

Diagnosis:**Differential diagnosis:**

1. Plantar wart: can usually be seen
2. Fracture calcaneum: follows quite severe trauma
3. Sever's disease (osteochondritis of the calcaneum) tender at the Achilles tendon insertion

Management:

1. NSAIDs R/VOLTAREN 50 1x3
2. FOOTWEAR كعب
3. Injection of hydrocortisone (Kenacort) with local anaesthesia:
 - Warn the patient that the symptoms will get temporarily worse over the coming 24 hrs
 - Injection can be repeated 2 or 3 times at intervals of 3 weeks

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Put in your mind

1. Inflamed joint: tender, hot, swollen
2. Some causes of joint pain: unaccustomed use, repeated overuse, viral illness, gout, osteoarthritis
3. Gout presents most commonly in middle aged males
4. Gout often affects big toe.
5. Gout nodule present around ears, bursae or tendons
6. In gout sr. uric acid is usually raised but is non-specific
7. Thiazides, alcohol precipitate gout
8. Don't use allopurinol in acute gout. It will worsen the symptoms
9. The most common joint disease seen in GP is osteoarthritis
10. In osteoarthritis male to female = 3:1, usually > 50 yrs
11. In osteoarthritis there is: crepitus which worse at the end of the day, joint stiffness after rest up to 30 minutes, early morning stiffness.
12. Shoulder pain can be a symptom of problems in the neck such as cervical spondylosis
13. Shoulder pain is usually caused by adhesive capsulitis (frozen shoulder)
14. Frozen shoulder affects patients 40-60 yrs
15. In frozen shoulder: painful stiff shoulder with global limitation of movement especially external rotation, pain is often worse at night.
16. In RA: Female to male = 2:1; peak onset is at 4th-5th decades.
17. In RA: joint pain [symmetrical / morning stiffness / especially in the small joints of the hands and feet / the distal inter-phalangeal joints are usually spared]
18. If you suspected RA refer early
19. Acute onset of Lumbar back pain usually follows lifting and often radiates to the buttocks or legs
20. In Back pain exclude pain referred to the back (GI or GU pain)
21. In Gout exclude kidney damage.
22. True Sciatica (irritation of sciatic nerve) radiates into the buttocks, back of the thigh and below the knee into the calf and ankle and is usually due to a prolapsed disc.
23. In acute back pain, advise to avoid bed rest.
24. Osteoporosis is most common in post menopausal women
25. Polymyalgia rheumatica (PMR) is mainly affecting women > 55 yrs
26. Giant cell arthritis (GCA): Headache, unilateral temporal artery tenderness, scalp tenderness.

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27. GCA is an ophthalmological emergency due to risk of sudden blindness
28. If you suspected GCA refer urgently to ophthalmologist
29. If you suspected PMR don't wait ESR results start immediately
30. Prednisolone 40-60 mg/day
31. In PMR and GCA exclude hypothyroidism
32. PMR and GCA need steroids for ≥ 2 yrs so prevent osteoporosis
33. Tenosynovitis is inflammation of the tendons of the dorsum of the hand or foot and commonly follows repetitive over use
34. Carpal tunnel syndrome is the most cause of paraesthesia in GP
35. Ganglion is a firm, cystic swelling usually around the dorsum of the wrist or hand and can be also around the ankle.
36. Sprained ankle is usually due to inversion of the ankle damaging the lateral talo-fibular ligament.

Test yourself

1. Presentation of inflamed joints is
2. One drug causing gout
3. The most common joint disease seen in GP is
4. Prescribe for a case of osteoarthritis?
5. Prescribe for sprained ankle?
6. في حالة القرص: ممنوع تناول الأطعمة التالية
7. True sciatica radiates into:
8. What is ganglion?
9. Lines of ttt of gout are
10. Joint stiffness of osteoarthritis occurs in (the evening, the morning, at the end of the day)
11. Peak onset of rheumatoid arthritis is decades
12. GCA is a/an emergency
13. Gout usually affect males (age?)
14. Symptoms of giant cell arteritis are
15. Give Zyloric during attack of gout & avoid it during attack (chronic/acute)
16. Morning stiffness is seen in
17. Joint gelling means & occurs with
18. Prescribe (management) for acute back pain?
19. Gout affects any joint but usually
20. PMR is mainly affecting women > years

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Answers

1. Hotness, tenderness, swelling, limitation of movement
2. Thiazide diuretics
3. Osteoarthritis
4. قرص قبل النوم
R/Omez 10 1x1 قرص قبل النوم
R/Panadol 500 قرص عند النوم
R/Glucosamine cap. 1x3 3 مرات يومياً
صالح: أوك قبل كثير، تجنب الجري، أكثر من المشي، قل من صلح السلم
5. RICE
Mobilize gently after 24 hrs
R/Reparil gel 1x3 or R/Ambezim 1x3
R/Reparil 40 1x3
R/Xefo 8, 16 1x3
النعوم، الكلى، الكبد، الحصى، البوليوات، السباح، الكرب، جيش الغراب والكحول
6. Buttocks, back of the thigh, below the knee
7. Firm, cystic swelling usually around the dorsum of the wrist or the hand
8. NSAIDs (Indocid, Colchicine, Allopurinol)
9. The morning
10. 4th, 5th
11. Ophthalmic
12. Middle aged
13. Headache, scalp tenderness, unilateral temporal tenderness.
14. Acute - chronic
15. OA, RA
16. Stiffness after rest up to 30 min. - osteoarthritis
17. عند النوم
R/Often amp قرص
R/Myolgen cap. 1x3
Or R/Simulat 1x1
Avoid bed rest
X-ray
18. Big toe
19. 55
20. 55

ثم فصل الروماتيزم والله تعالى الفضل والمنة

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